FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040410

Facility Name: ELMWOOD CARE, INC.

Address: 7733 W. GRAND AVE (Number) ELMWOOD PARK (City) 60635 (Zip Code)

County: COOK

Telephone Number: (708) 452-9200 **Fax #** (708) 452-9294

IDPA ID Number: 36-3868389

Date of Initial License for Current Owners: 04/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANT'S REPORT ATTACHED (Date)
	(Print Name and Title)	CARY C. BUXBAUM, C.P.A.
	(Firm Name & Address)	FROST, RUTTENBERG & ROTHBLATT, P.C. 111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015
	(Telephone)	(847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds n/a

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	245	Skilled (SNF)	245	89,670	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	245	TOTALS	245	89,670	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	35,465	3,094	3,770	42,329	8
9	SNF/PED					9
10	ICF	30,997	3,093	1,528	35,618	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	66,462	6,187	5,298	77,947	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.93%

D. How many bed-hold days during this year were paid by Public Aid? 570 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 23 and days of care provided 3,329

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	274,268	34,023	41,101	349,392		349,392	(12,205)	337,187			1
2	Food Purchase		310,794		310,794	(33,687)	277,107	(245)	276,862			2
3	Housekeeping	170,186	35,385		205,571		205,571	711	206,282			3
4	Laundry	52,844	35,801		88,645		88,645		88,645			4
5	Heat and Other Utilities			159,860	159,860		159,860	2,597	162,457			5
6	Maintenance	32,519	22,625	176,690	231,834		231,834	(66,139)	165,695			6
7	Other (specify):*							7,606	7,606			7
8	**TOTAL General Services**	529,817	438,628	377,651	1,346,096	(33,687)	1,312,409	(67,675)	1,244,734			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	2,241,711	159,768	271,334	2,672,813		2,672,813	(42,794)	2,630,019			10
10a	Therapy	73,062		12,976	86,038		86,038		86,038			10a
11	Activities	66,159	4,074	2,193	72,426		72,426		72,426			11
12	Social Services	66,393		3,325	69,718		69,718		69,718			12
13	Nurse Aide Training											13
14	Program Transportation			802	802		802		802			14
15	Other (specify):*							3,704	3,704			15
16	**TOTAL Health Care and Programs**	2,447,325	163,842	295,430	2,906,597		2,906,597	(39,090)	2,867,507			16
	C. General Administration											
17	Administrative	147,005		520,564	667,569		667,569	(384,468)	283,101			17
18	Directors Fees											18
19	Professional Services			244,320	244,320		244,320	(146,809)	97,511			19
20	Dues, Fees, Subscriptions & Promotions			68,037	68,037		68,037	(19,520)	48,517			20
21	Clerical & General Office Expenses	60,188	28,510	126,502	215,200		215,200	(20,652)	194,548			21
22	Employee Benefits & Payroll Taxes			437,159	437,159	33,687	470,846		470,846			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,445	1,445		1,445	891	2,336			24
25	Other Admin. Staff Transportation			267	267		267	3,763	4,030			25
26	Insurance-Prop.Liab.Malpractice			105,780	105,780		105,780	1,169	106,949			26
27	Other (specify):*							28,683	28,683			27
28	**TOTAL General Administration**	207,193	28,510	1,504,074	1,739,777	33,687	1,773,464	(536,943)	1,236,521			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,184,335	630,980	2,177,155	5,992,470		5,992,470	(643,708)	5,348,762			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

ELMWOOD CARE, INC.
0040410
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	33,687	
2	FOOD		33,687

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number ELMWOOD CARE, INC. #0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			107,923	107,923		107,923	423,818	531,741			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,629	32,629		32,629	1,358,716	1,391,345			32
33	Real Estate Taxes			497,965	497,965		497,965	4,076	502,041			33
34	Rent-Facility & Grounds			1,735,907	1,735,907		1,735,907	(1,735,907)				34
35	Rent-Equipment & Vehicles			9,338	9,338		9,338	10,856	20,194			35
36	Other (specify):*							19,385	19,385			36
37	**TOTAL Ownership**			2,383,762	2,383,762		2,383,762	80,944	2,464,706			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		110,418	203,888	314,306		314,306	(19,105)	295,201			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			134,506	134,506		134,506		134,506			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		110,418	338,394	448,812		448,812	(19,105)	429,707			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,184,335	741,398	4,899,311	8,825,044		8,825,044	(581,869)	8,243,175			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	43,634	30		9
10	Interest and Other Investment Income	(406)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(245)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(80,369)	21		24
25	Fund Raising, Advertising and Promotional	(11,020)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(9,588)	20		28
29	Other-Attach Schedule	(101,469)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (159,463)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(422,406)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (422,406)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (581,869)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

ELMWOOD CARE, INC.

ID# 0040410

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$ 4,633	6	1
2	ICLTC Cope Contribution	(319)	20	2
3	Veterans' expenses	(6,787)	10	3
4	Trust Fees	(150)	20	4
5	Collection Fees	(284)	19	5
6	Capitalized R&M	(44,241)	6	6
7	Capitalized R&M	(2,081)	6	7
8	p/y ancillary charges	(6,130)	39	8
9	Late fees - Elmwood Bldg Partnership	(1,766)	32	9
10	Real Estate tax penalty	(125)	20	10
11	Non-allowable legal fees	(42,843)	19	11
12	Jury Duty - CNAs	(69)	10	12
13	Real Estate Tax Penalty	(1,219)	33	13
14	Depreciation	(88)	30	14
15				15
16				16
17				17
18				18
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87				87
88				88
89				89
90	Total	(101,469)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary					(25,582)			13,377				(12,205)	1
2	Food Purchase	(245)											(245)	2
3	Housekeeping			711									711	3
4	Laundry													4
5	Heat and Other Utilities			959	1,638								2,597	5
6	Maintenance	(41,689)		592	(14,340)	(10,702)							(66,139)	6
7	Other (specify):*				879	6,727							7,606	7
8	**TOTAL General Services**	(41,934)		2,262	(11,823)	(29,557)			13,377				(67,675)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(6,856)			(26,629)				(9,309)				(42,794)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				3,704								3,704	15
16	**TOTAL Health Care and Programs**	(6,856)			(22,925)				(9,309)				(39,090)	16
	C. General Administration													
17	Administrative			16,591	(77,239)	(329,457)		5,637					(384,468)	17
18	Directors Fees													18
19	Professional Services	(43,127)		(100,313)	(17,162)	13,775		18					(146,809)	19
20	Fees, Subscriptions & Promotions	(21,202)		427	1,243			12					(19,520)	20
21	Clerical & General Office Expenses	(80,369)		55,089	4,602			26					(20,652)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			217	674								891	24
25	Other Admin. Staff Transportation			754	3,009								3,763	25
26	Insurance-Prop.Liab.Malpractice			484	663			22					1,169	26
27	Other (specify):*			8,655	5,550	13,889		589					28,683	27
28	**TOTAL General Administration**	(144,698)		(18,096)	(78,660)	(301,793)		6,304					(536,943)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(193,488)		(15,834)	(113,408)	(331,350)		6,304	4,068				(643,708)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	43,546	370,547	3,536	6,189								423,818	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,172)	1,355,825	1,380	3,666			17					1,358,716	32
33	Real Estate Taxes	(1,219)		1,785	3,510								4,076	33
34	Rent-Facility & Grounds		(1,735,907)										(1,735,907)	34
35	Rent-Equipment & Vehicles			3,051	7,493			312					10,856	35
36	Other (specify):*		19,385										19,385	36
37	**TOTAL Ownership**	40,155	9,850	9,752	20,858			329					80,944	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(6,130)							(12,975)				(19,105)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	(6,130)							(12,975)				(19,105)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(159,463)	9,850	(6,082)	(92,550)	(331,350)		6,633	(8,907)				(581,869)	45

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Schedule Attached		See Schedule Attached		See Schedule Attached		
				Elmwood Care Bldg, LLC	Lincolnwood	Building Partnership

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Expense	$ 1,735,907	Elmwood Building , LLC	100.00%	$	$ (1,735,907)	1
2	V	32	Interest Expense		Elmwood Building , LLC	100.00%	1,354,059	1,354,059	2
3	V	30	Depreciation		Elmwood Building , LLC	100.00%	370,547	370,547	3
4	V	36	Amortization		Elmwood Building , LLC	100.00%	6,667	6,667	4
5	V	36	Assignment Fee Expense		Elmwood Building , LLC	100.00%	12,718	12,718	5
6	V	32	Late Fee Expense		Elmwood Building , LLC	100.00%	1,766	1,766	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,735,907			$ 1,745,757	$ * 9,850	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	PREFERRED BOOKKEEPING	100.00%	$ 711	$ 711	15
16	V	5	UTILITIES		PREFERRED BOOKKEEPING	100.00%	959	959	16
17	V	6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	592	592	17
18	V	17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	16,591	16,591	18
19	V	19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	2,207	2,207	19
20	V	20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	427	427	20
21	V	21	CLERICAL		PREFERRED BOOKKEEPING	100.00%	55,089	55,089	21
22	V	24	SEMINARS		PREFERRED BOOKKEEPING	100.00%	217	217	22
23	V	25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	754	754	23
24	V	26	INSURANCE		PREFERRED BOOKKEEPING	100.00%	484	484	24
25	V	27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	8,655	8,655	25
26	V	30	DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	3,536	3,536	26
27	V	32	INTEREST		PREFERRED BOOKKEEPING	100.00%	1,380	1,380	27
28	V	33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	1,785	1,785	28
29	V	35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	3,051	3,051	29
30	V								30
31	V								31
32	V	19	ACCOUNT./BOOKKEEPING	102,520	PREFERRED BOOKKEEPING	100.00%		(102,520)	32
33	V	19	COMPUTER	5,880	PREFERRED BOOKKEEPING	100.00%	5,880		33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 108,400			$ 102,318	$ * (6,082)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.I.R. MANAGEMENT, INC.	100.00%	$ 1,638	$ 1,638	15
16	V	6	REPAIRS AND MAINT.	22,056	S.I.R. MANAGEMENT, INC.	100.00%	7,716	(14,340)	16
17	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	879	879	17
18	V	10	NURSING	48,516	S.I.R. MANAGEMENT, INC.	100.00%	21,887	(26,629)	18
19	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,704	3,704	19
20	V	17	ADMINISTRATIVE	85,968	S.I.R. MANAGEMENT, INC.	100.00%	8,729	(77,239)	20
21	V	19	PROFESSIONAL FEES	19,848	S.I.R. MANAGEMENT, INC.	100.00%	2,686	(17,162)	21
22	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	1,243	1,243	22
23	V	21	CLERICAL & GENERAL	24,996	S.I.R. MANAGEMENT, INC.	100.00%	29,598	4,602	23
24	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	674	674	24
25	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	3,009	3,009	25
26	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	663	663	26
27	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	5,550	5,550	27
28	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	6,189	6,189	28
29	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,666	3,666	29
30	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,510	3,510	30
31	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	7,493	7,493	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 201,384			$ 108,834	$ * (92,550)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 24,996	S.I.R. MANAGEMENT, INC.	100.00%	$ 6,319	$ (18,677)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,063	1,063	16
17	V	17	ADMIN./LEGAL SALARIES	430,276	S.I.R. MANAGEMENT, INC.	100.00%	100,819	(329,457)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	13,775	13,775	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	13,889	13,889	19
20	V								20
21	V								21
22	V	10A	SPECIAL REHAB	0	S.I.R. MANAGEMENT, INC.	100.00%	0		22
23	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	0		23
24	V								24
25	V								25
26	V	6	REPAIRS AND MAINT.	35,200	S.I.R. MANAGEMENT, INC.	100.00%	24,498	(10,702)	26
27	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	4,265	4,265	27
28	V								28
29	V								29
30	V	1	DIETICIAN SALARIES	15,000	S.I.R. MANAGEMENT, INC.	100.00%	8,095	(6,905)	30
31	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,399	1,399	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 505,472			$ 174,122	$ * (331,350)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 80,367	$ 80,367	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	80,367	CCS EMPLOYEE BENEFIT GROUP	100.00%		(80,367)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 80,367			$ 80,367	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	ECM OWNERS COUNCIL	100.00%	$ 18	$ 18	15
16	V	20	DUES, FEES & SUBSCRIPTIONS		ECM OWNERS COUNCIL	100.00%	12	12	16
17	V	21	CLERICAL		ECM OWNERS COUNCIL	100.00%	26	26	17
18	V	26	INSURANCE		ECM OWNERS COUNCIL	100.00%	22	22	18
19	V	32	INTEREST		ECM OWNERS COUNCIL	100.00%	17	17	19
20	V	35	VEHICLE RENTAL		ECM OWNERS COUNCIL	100.00%	312	312	20
21	V	17	MANAGEMENT FEES	4,320	ECM OWNERS COUNCIL	100.00%		(4,320)	21
22	V								22
23	V	17	ADMIN. SAL. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	10,118	10,118	23
24	V	27	EMP. BEN. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	589	589	24
25	V	17	ADMIN. SALARY		ECM OWNERS COUNCIL	100.00%	(161)	(161)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,320			$ 10,953	$ * 6,633	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	ENTERAL EQUIPMENT	$ 15,493	PARAMOUNT HEALTH CARE SYSTEMS	100.00%	$ 2,518	$ (12,975)	15
16	V	10	ENTERAL EQUIPMENT	9,956	PARAMOUNT HEALTH CARE SYSTEMS	100.00%	647	(9,309)	16
17	V	1	NUTRITIONAL SUPPLEMENTS		PARAMOUNT HEALTH CARE SYSTEMS	100.00%	13,377	13,377	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 25,449			$ 16,542	$ * (8,907)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Lori Barrish	Stockholder	Administrative	2.04%	NONE	40	100.00%	Salary	$ 87,873	17-1	1
2	Bryan Barrish	Stockholder	Administrative	28.27%	see attached	5.46	10.92%	Alloc. Salary	31,864	17-7	2
3	Mike Giannini	Stockholder	Administrative	11.48%	see attached	4.85	9.70%	Alloc. Salary	29,148	17-7	3
4	Louise Bergthold	Stockholder	Administrative	4.90%	see attached	6.67	12.13%	Alloc. Salary	20,615	17-7	4
5	Joey Abramchik	Stockholder	Administrative	2.04%	see attached	6.06	12.12%	Alloc. Fees	13,775	17-7	5
6	Tom Winter	Stockholder	Administrative	1.43%	see attached	7	11.67%	Alloc. Salary	16,591	17-7	6
7	Stuart Sikes	Stockholder	Administrative	0.82%	see attached	4.85	12.13%	Alloc. Fees	12,717	17-7	7
8	Jeff Oravec	Stockholder	Administrative	0.41%	see attached	4.85	12.13%	Alloc. Salary	8,477	17-7	8
9	Arturo Rominiquit	Relative	Clerical	0.00	see attached	4.67	11.68%	Alloc. Salary	2,551	21-7	9
10	Nenita Guzman	Relative	Dietary	0.00	see attached	6.67	12.13%	Alloc. Salary	6,319	1-7	10
11	Eric Rothner	Relative	Administrative	0.00	see attached	0.76	1.06%	Alloc. Salary	8,114	17-7	11
12											12
13								TOTAL	$ 238,044		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREFERRED BOOKEEPING SERVICES
Street Address: 4100 WEST PRATT AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 674-5200
Fax Number: (847) 674-5267

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	878,492	11	$ 6,088	$	102,520	$ 711	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	878,492	11	8,220		102,520	959	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	878,492	11	5,069		102,520	592	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	878,492	11	142,165	142,165	102,520	16,591	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	878,492	11	18,910		102,520	2,207	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	878,492	11	3,657		102,520	427	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	878,492	11	472,061	403,426	102,520	55,089	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	878,492	11	1,858		102,520	217	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	878,492	11	6,465		102,520	754	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	878,492	11	4,146		102,520	484	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	878,492	11	74,163		102,520	8,655	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	878,492	11	30,298		102,520	3,536	12
13	32	INTEREST	BOOK./ACCNT.INCOME	878,492	11	11,823		102,520	1,380	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	878,492	11	15,297		102,520	1,785	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	878,492	11	26,147		102,520	3,051	15
16										16
17										17
18										18
19	19	COMPUTER	DIRECT ALLOCATION						5,880	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 826,367	$ 545,591		$ 102,318	25

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	642,911	10	$ 13,508	$	77,947	$ 1,638	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	642,911	10	63,644	42,834	77,947	7,716	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	642,911	10	7,250		77,947	879	3
4	10	NURSING	PATIENT DAYS	642,911	10	180,529	180,529	77,947	21,887	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	642,911	10	30,553		77,947	3,704	5
6	17	ADMINISTRATIVE	PATIENT DAYS	642,911	10	71,994	71,994	77,947	8,729	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	642,911	10	22,153		77,947	2,686	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	642,911	10	10,256		77,947	1,243	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	642,911	10	244,124	177,193	77,947	29,598	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	642,911	10	5,556		77,947	674	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	642,911	10	24,821		77,947	3,009	11
12	26	INSURANCE	PATIENT DAYS	642,911	10	5,468		77,947	663	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	642,911	10	45,778		77,947	5,550	13
14	30	DEPRECIATION	PATIENT DAYS	642,911	10	51,045		77,947	6,189	14
15	32	INTEREST	PATIENT DAYS	642,911	10	30,234		77,947	3,666	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	642,911	10	28,948		77,947	3,510	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	642,911	10	61,803		77,947	7,493	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 897,664	$ 472,550		$ 108,834	25

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	642,911	10	$ 52,122	$ 52,122	77,947	$ 6,319	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	642,911	10	8,770		77,947	1,063	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	642,911	10	831,558	831,558	77,947	100,819	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	642,911	10	113,620		77,947	13,775	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	642,911	10	$ 114,558	$	77,947	$ 13,889	5
6										6
7										7
8	10A	SPECIAL REHAB	SPECIAL REHAB INC.	82,944	4	56,277	56,277			8
9	15	EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	82,944	4	$ 9,470	$		$	9
10										10
11										11
12	6	REPAIRS AND MAINT.	MAINTENANCE INC.	237,604	10	165,366	165,366	35,200	24,498	12
13	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	237,604	10	$ 28,790	$	35,200	$ 4,265	13
14										14
15										15
16	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	67,672	67,672	15,000	8,095	16
17	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	11,698		15,000	1,399	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,459,901	$ 1,172,995		$ 174,122	25

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 80,367	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 80,367	25

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ECM OWNERS COUNCIL
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 676-2026
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ECMOC MGMNT FEE INC.	96,000	9	$ 400	$	4,320	$ 18	1
2	20	DUES, FEES & SUBSCRIPTION	ECMOC MGMNT FEE INC.	96,000	9	264		4,320	12	2
3	21	CLERICAL	ECMOC MGMNT FEE INC.	96,000	9	579		4,320	26	3
4	26	INSURANCE	ECMOC MGMNT FEE INC.	96,000	9	496		4,320	22	4
5	32	INTEREST	ECMOC MGMNT FEE INC.	96,000	9	374		4,320	17	5
6	35	VEHICLE RENTAL	ECMOC MGMNT FEE INC.	96,000	9	6,931		4,320	312	6
7										7
8										8
9	17	ADMIN. SAL. - M. GIANNINI	ADMIN. HOURS	39	9	81,858	81,858	5	10,118	9
10	27	EMP. BEN. - M. GIANNINI	ADMIN. HOURS	39	9	4,762		5	589	10
11	17	ADMIN. SALARY	DIRECT ALLOCATION						(161)	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 95,664	$ 81,858		$ 10,953	25

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PARAMOUNT HEALTH CARE SYSTEMS
Street Address: 6300 OAKTON
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847)470-4700
Fax Number: (847)470-4718

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	ENTERAL EQUIPMENT	DIRECT ALLOCATION						2,518	1
2	10	ENTERAL EQUIPMENT	DIRECT ALLOCATION						647	2
3	1	NUTRITIONAL SUPPLEMENTS	DIRECT ALLOCATION						13,377	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 16,542	25

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CIB Bank/S.I.R. Line		X	WORKING CAPITAL				460,000		PRIME	29,782	6
7	HORTON INSUR. AGENCY		X	INSURANCE	$258.70	1/4/00					2,847	7
8												8
9	TOTAL Facility Related				$258.70		$	$ 460,000			$ 32,629	9
	B. Non-Facility Related*											
10	Supplemental Schedule										1,358,716	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,358,716	14
15	TOTALS (line 9+line14)						$	$ 460,000			$ 1,391,345	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income						$	$			$ (406)	1
2	Allocation Elmwood Building	X		Capitalized Lease							1,354,059	2
3	Allocation Preferred Bkkpg	X									1,380	3
4	Allocation ECM	X									17	4
5	Allocation SIR Mgmt	X									3,666	5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 1,358,716	21

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	440,400	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	466,941	2
3. Under or (over) accrual (line 2 minus line 1).	$	26,541	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	475,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	502,041	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	396,516	8
	1996	407,376	9
	1997	418,058	10
	1998	427,944	11
	1999	461,646	12

2000 tax accrual = actual tax X 1.03; 461646 X 1.03 = 475495 (rounded)

Allocations - Preferred Bookkeeping = 1,785; SIR Mgmt = 3,510

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,565 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1993	$ 627,991	1
2			1998	100,000	2
3	TOTALS			$ 727,991	3

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	245		1994		$ 11,931,834	$ 305,944	35	$ 340,910	$ 34,966	$ 2,150,718	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	129,203	1,666	20	6,460	4,794	47,065	9
10	Various			1994	49,738	208	20	2,487	2,279	16,272	10
11	Various			1995	167,102	6,238	20	8,357	2,119	46,247	11
12	CARPETING			1996	49,690	5,725	20	2,485	(3,240)	10,354	12
13	PUMP MOTOR			1996	4,932	126	20	247	121	1,194	13
14	PUMPS			1996	1,524	175	20	76	(99)	367	14
15	Landscape			1996	6,425	445	20	321	(124)	1,498	15
16	ROOM DIVIDERS			1996	8,662	997	20	433	(564)	1,840	16
17	WATER VALVES			1996	6,127	157	20	306	149	1,275	17
18	NEW COMPRESSOR			1996	11,361	291	20	568	277	2,509	18
19	ELEVATOR WORK			1996	36,943	947	20	1,847	900	8,158	19
20	ELEVATOR WORK			1996	2,181	56	20	109	53	536	20
21	ASPHALT WORK			1996	5,825	403	20	291	(112)	1,358	21
22	SIGN			1996	2,420	279	20	121	(158)	595	22
23	FIRE HOSE			1997	1,085		20	54	54	171	23
24											24
25	PAGE 12-1 REP TOTALS				97,943	4,047		3,813	(234)	21,440	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33	PAGE 12C TOTALS				67,583	8,588		1,736	(6,852)	1,736	33
34	PAGE 12B TOTALS				159,842	12,842		8,275	(4,567)	13,633	34
35	PAGE 12A TOTALS				155,183	14,986		8,753	(6,233)	23,426	35
36	TOTAL (lines 4 thru 35)				$ 12,895,603	$ 364,120		$ 387,649	$ 23,529	$ 2,350,392	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CIRCUIT BREAKER			1997	1,366		20	68	68	244	9
10	WATER TOWER			1997	1,431		20	72	72	264	10
11	CONCRETE RAMP			1997	2,550	65	20	128	63	480	11
12	WINDOW DECOR			1997	1,503		20	75	75	263	12
13	PUMP			1997	1,657		20	83	83	270	13
14	AIR HANDLER			1997	3,200	364	20	160	(204)	573	14
15	CONCRETE FLOOR			1997	2,200		20	110	110	422	15
16	AIR HANDLER			1997	1,188		20	59	59	182	16
17	REMODEL N.STATION			1998	8,507	1,633	20	425	(1,208)	1,098	17
18	GLASS DOOR			1998	3,756		20	188	188	188	18
19	NURSES STATION WORK			1998	27,371	5,255	20	1,369	(3,886)	3,651	19
20	ELEVATOR WORK			1998	3,632	93	20	182	89	516	20
21	ROOF WORK			1998	2,200	56	20	110	54	303	21
22	REPLACEMENT WINDOWS			1998	3,890	100	20	195	95	553	22
23	COMPRESSOR			1998	1,349		20	67	67	156	23
24	FLOORING			1998	27,482	705	20	1,374	669	3,893	24
25	WATER VALVES			1998	1,416		20	71	71	207	25
26	ELECTRICAL WIRING			1998	1,642		20	82	82	178	26
27	HEATING LINE			1998	1,495		20	75	75	206	27
28	COMPRESSOR			1998	3,620		20	181	181	437	28
29	CARPETING			1998	3,090	593	20	155	(438)	336	29
30	HAND RAILS			1998	19,827	3,807	20	1,983	(1,824)	5,123	30
31	BLINDS			1998	9,051	1,738	20	453	(1,285)	1,170	31
32	BLINDS			1998	1,336	256	20	67	(189)	173	32
33	DRAPERIES			1998	3,958		20	198	198	479	33
34	TUCKPOINTING			1998	12,500	321	20	625	304	1,615	34
35	PAINTING &DECORATING			1998	3,966		20	198	198	446	35
36	TOTAL (lines 4 thru 35)				$ 155,183	$ 14,986		$ 8,753	$ (6,233)	$ 23,426	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	TILES			1998	4,157	107	20	208	101	537	9
10	FLOORING-CARPET			1998	3,745		20	187	187	514	10
11	HAND RAILS			1998	5,636	1,082	20	564	(518)	1,269	11
12	IRON RAILINGS			1998	2,925	75	20	146	71	414	12
13	PAINTING &DECORATING			1998	4,233		20	212	212	495	13
14	MIXING VALVE			1998	1,127		20	56	56	168	14
15	MURAL			1999	800		20	40	40	77	15
16	QUARRY TILE			1999	1,309		20	65	65	70	16
17	SPRINKLER			1999	3,224		20	161	161	161	17
18	CONCRETE PIPES			1999	3,600		20	180	180	345	18
19	INTERIOR SIGNS			1999	3,956		20	198	198	363	19
20	DUCT CLEANING			1999	2,668		20	133	133	233	20
21	LANDSCAPING			1999	17,036	1,618	20	852	(766)	1,207	21
22	S.I.R. ALLOCATION			1999	13,707	351	20	685	334	799	22
23	HVAC WORK			1999	3,078	79	20	154	75	231	23
24	CUBICLE CURTAINS			1999	1,009		20	50	50	67	24
25	PAINT & WALLPAPER			1999	14,333		20	717	717	1,195	25
26	PATIO WORK			1999	11,600	1,102	20	580	(522)	773	26
27	FENCING			1999	3,458	329	20	173	(156)	245	27
28	ELEVATOR WORK			1999	10,895	3,486	20	545	(2,941)	818	28
29	ELEVATOR WORK			1999	2,895	926	20	145	(781)	290	29
30	HVAC			1999	2,728		20	136	136	170	30
31	FIRE DOORS			1999	3,476	1,112	20	174	(938)	334	31
32	POARKING LOT			1999	24,171	2,296	20	1,209	(1,087)	1,814	32
33	DISCHGE DOOR			1999	1,435		20	72	72	78	33
34	HVAC COMPRESSOR			1999	10,891	279	20	545	266	863	34
35	DRIER EXHAUST			1999	1,750		20	88	88	103	35
36	TOTAL (lines 4 thru 35)				$ 159,842	$ 12,842		$ 8,275	$ (4,567)	$ 13,633	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	HVAC WORK			2000	9,373	1,875	20	274	(1,601)	274	9
10	HVAC WORK			2000	12,416	2,483	20	311	(2,172)	311	10
11	FIRE PANEL			2000	8,650	1,730	20	361	(1,369)	361	11
12	ELECTRICAL WIRING			2000	7,700	1,540	20	257	(1,283)	257	12
13	ELECTRICAL WIRING			2000	4,800	960	20	100	(860)	100	13
14	SEWER WORK			2000	850		20	18	18	18	14
15	JRC SEWER			2000	2,250		20	38	38	38	15
16	FREEZER WORK			2000	2,455		20	41	41	41	16
17	bearing assembly			2000	1,242		20	26	26	26	17
18	TILE			2000	1,371		20	17	17	17	18
19	SEWER WORK			2000	2,800		20	82	82	82	19
20	1/12 HP motor			2000	839		20	17	17	17	20
21	DOORS			2000	4,012		20	50	50	50	21
22	DRYWALL			2000	1,085		20	45	45	45	22
23	MIXING VALVE			2000	753		20	16	16	16	23
24	PUMP			2000	1,778		20	30	30	30	24
25	PAINT			2000	688		20	11	11	11	25
26	WIRING			2000	1,226		20	20	20	20	26
27	BLOCK HEATER			2000	1,044		20	4	4	4	27
28	PLUMBING			2000	675		20	3	3	3	28
29	PAINTING			2000	650		20	3	3	3	29
30	ELECTRIC WIRING			2000			20				30
31	PRIVACY CURTAINS			2000	926		20	12	12	12	31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 67,583	$ 8,588		$ 1,736	$ (6,852)	$ 1,736	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
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17											17
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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16											16
17											17
18											18
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
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18											18
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
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15											15
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17											17
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1993	Alloc. - sir	$ 16,479	$ 523	35	$ 471	$ (52)	$ 3,531	4
5			1993	Alloc. - sir	32,397	1,029	35	926	(103)	6,942	5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation from Preferred Bookkeeping			1997	20,579	776	20	1,029	253	3,919	9
10	Allocation from Preferred Bookkeeping			1999	163	52	20	8	(44)	12	10
11	Allocation from Preferred Bookkeeping			2000	1,032		20	21	21	21	11
12	Allocation from SIR Properties - Preferred Bookkeeping			1999	2,088	209	20	104	(105)	157	12
13	Allocation from SIR Properties - Preferred Bookkeeping			1998	998	100	20	50	(50)	125	13
14	Allocation from SIR Properties - Preferred Bookkeeping			1997	62	6	20	3	(3)	14	14
15	Allocation from SIR Properties - Preferred Bookkeeping			1994	157	4	20	8	4	51	15
16	Allocation from SIR Properties - Preferred Bookkeeping			1993	267	14	20	13	(1)	100	16
17	Allocation from SIR Management			1993	13,914	462	20	702	240	5,484	17
18	Allocation from SIR Management			1994	43		20	4	4	28	18
19	Allocation from SIR Management			1995	318	18	20	16	(2)	86	19
20	Allocation from SIR Management			1999	1,511	100	20	76	(24)	92	20
21	Allocation from SIR Management			2000	912	99	20	32	(67)	32	21
22	Allocation from SIR Properties - SIR Management			1999	4,105	411	20	205	(206)	308	22
23	Allocation from SIR Properties - SIR Management			1998	1,962	196	20	98	(98)	245	23
24	Allocation from SIR Properties - SIR Management			1997	122	12	20	6	(6)	27	24
25	Allocation from SIR Properties - SIR Management			1994	309	8	20	15	7	100	25
26	Allocation from SIR Properties - SIR Management			1993	525	28	20	26	(2)	166	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 97,943	$ 4,047		$ 3,813	$ (234)	$ 21,440	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,429,674	$ 118,453	$ 142,356	$ 23,903		$ 988,306	37
38	Current Year Purchases	25,354	4,815	1,736	(3,079)		1,736	38
39	Fully Depreciated Assets		719		(719)			39
40								40
41	TOTALS	$ 1,455,028	$ 123,987	$ 144,092	$ 20,105		$ 990,042	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$	15,078,622	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	488,107	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	531,741	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	43,634	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	3,340,434	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

ELMWOOD CARE, INC.
0040410
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
Elmwood Care, Inc.	624,837	48,564	62,044	13,480	329,255
Elmwood Building LLC	735,000	64,603	73,500	8,897	615,000
Preferred Bookkeeping	23,907	1,712	2,218	506	14,663
SIR Properties - Preferred Bookkeeping	15		2	2	12
SIR Management	45,885	3,574	4,589	1,015	29,353
SIR Properties - SIR Management	30		3	3	23
TOTALS	1,429,674	118,453	142,356	23,903	988,306
LINE 29: CURRENT YEAR					
Elmwood Care, Inc.	23,219	4,425	1,608	(2,817)	1,608
Elmwood Building LLC					
Preferred Bookkeeping	696	139	58	(81)	58
SIR Properties - Preferred Bookkeeping					
SIR Management	1,439	251	70	(181)	70
SIR Properties - SIR Management					
TOTALS	25,354	4,815	1,736	(3,079)	1,736
LINE 30: FULLY DEPRECIATED					
Elmwood Care, Inc.		719		(719)	
Elmwood Building LLC					
Preferred Bookkeeping					
SIR Properties - Preferred Bookkeeping					
SIR Management					
SIR Properties - SIR Management					
TOTALS		719		(719)	
TOTALS (Should Tie to Totals on Page 13)					
Elmwood Care, Inc.	648,056	53,708	63,652	9,944	330,863
Elmwood Building LLC	735,000	64,603	73,500	8,897	615,000
Preferred Bookkeeping	24,603	1,851	2,276	425	14,721
SIR Properties - Preferred Bookkeeping	15		2	2	12
SIR Management	47,324	3,825	4,659	834	29,423
SIR Properties - SIR Management	30		3	3	23
TOTALS	1,455,028	123,987	144,092	20,105	990,042

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 5,060 Description: SEE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	98 Chevy Van	$ 440.00	$ 5,280	17
18	Allocation - ECM			312	18
19	Allocation - Pref.			2,335	19
20	Allocation - S.I.R.			7,207	20
21	TOTAL		$ 440.00	$ 15,134	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 69,368	$		$ 69,368	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			21,335			21,335	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			102,603			102,603	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				56,566		56,566	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-2, 39-3				3,005	6,897		9,902	12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**	39-2, 39-3				7,577	46,955		54,532	13
14	TOTAL			$		$ 203,888	$ 110,418		$ 314,306	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Therapy Supplies	4,785
2	Laboratory	1,200
3	Oxygen	15,454
4	Equipment Rental	2,612
5	X-Ray	890
6	Infusion Supplies	5,819
7	Enteral Supplies	15,493
8	Respiratory Therapy Supplies	702
9		
10		
		46,955

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	1,447
2	prior year therapy (adjusted out on p. 5)	6,130
3		
4		
5		
6		
7		
8		
9		
10		
		7,577

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 148,969	$ 149,069	1
2	Cash-Patient Deposits	79,265	79,265	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,069,115	1,069,115	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,317	8,317	6
7	Other Prepaid Expenses	116,109	990	7
8	Accounts Receivable (owners or related parties)		2,040	8
9	Other(specify): See supplemental schedule	371,739	371,739	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,793,514	$ 1,680,535	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		727,991	13
14	Buildings, at Historical Cost		11,931,834	14
15	Leasehold Improvements, at Historical Cos	396,126	396,126	15
16	Equipment, at Historical Cost	1,011,668	1,746,668	16
17	Accumulated Depreciation (book methods)	(934,935)	(3,597,370)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	91,058		22
23	Other(specify): See supplemental schedule		189,270	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 563,917	$ 11,394,519	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,357,431	$ 13,075,054	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 209,327	$ 209,327	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	94,185	94,185	28
29	Short-Term Notes Payable	460,000	460,000	29
30	Accrued Salaries Payable	247,442	247,442	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,471	17,471	31
32	Accrued Real Estate Taxes(Sch.IX-B)	475,500	475,500	32
33	Accrued Interest Payable	1,539	1,539	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	5,900	5,900	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	12,264	12,264	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,523,628	$ 1,523,628	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule		13,568,411	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 13,568,411	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,523,628	$ 15,092,039	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 833,803	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,357,431	$ #REF!	48

*(See instructions.)

Facility Name & ID Number ELMWOOD CARE, INC. **#** 0040410 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES As of 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow	283,763	283,763
Due from Others	87,976	87,976
	371,739	371,739

OTHER NON CURRENT ASSETS:		
Intangible - Net		56,664
Prepaid Assignment Fee		108,106
Option Deposit		24,500
		189,270

OTHER CURRENT LIABILITIES:	Amount	Amount
Due to IDPA - Audit	4,238	4,238
Due to Others	8,026	8,026
	12,264	12,264

OTHER NON CURRENT LIABILITIES:		
Capitalized Lease		13,568,411
		13,568,411

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,073,142	1
2	Restatements (describe):		2
3	Schedule attached		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,073,142	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(116,839)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(122,500)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (239,339)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 833,803	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	ELMWOOD CARE, INC.	#	0040410	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		1,073,142
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		1,073,142
Equity(Deficit) from Page 17 Col 1		833,803
Related Party		
Equity(Deficit)	-2840939	
Income	-9849	
		(2,850,788)
Combined Equity - End of Year		(2,016,985)

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,456,112	1
2	Discounts and Allowances for all Levels	(324,415)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,131,697	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	419,583	6
7	Oxygen	9,819	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 429,402	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	59,500	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	51,822	19
20	Radiology and X-Ray	1,780	20
21	Other Medical Services	32,505	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 145,607	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	406	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 406	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	1,093	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,093	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,708,205	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,346,096	31
32	Health Care	2,906,597	32
33	General Administration	1,739,777	33
	B. Capital Expense		
34	Ownership	2,383,762	34
	C. Ancillary Expense		
35	Special Cost Centers	314,306	35
36	Provider Participation Fee	134,506	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,825,044	40
41	**Income before Income Taxes (line 30 minus line 40)****	(116,839)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (116,839)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? cash basis If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	State Replacement Tax	1,024
2	Jury Duty - CNA: adjusted out on page 5	69
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	1,093

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,890	2,091	$ 95,005	$ 45.44	1
2	Assistant Director of Nursing	1,874	2,091	65,948	31.54	2
3	Registered Nurses	43,538	46,491	1,033,695	22.23	3
4	Licensed Practical Nurses	7,892	8,399	146,517	17.44	4
5	Nurse Aides & Orderlies	87,023	91,865	803,532	8.75	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,842	8,279	73,062	8.82	8
9	Activity Director	1,930	2,091	31,106	14.88	9
10	Activity Assistants	6,049	6,201	35,053	5.65	10
11	Social Service Workers	6,967	7,162	66,393	9.27	11
12	Dietician					12
13	Food Service Supervisor	2,050	2,251	34,391	15.28	13
14	Head Cook	8,608	9,378	89,562	9.55	14
15	Cook Helpers/Assistants	18,089	19,812	150,315	7.59	15
16	Dishwashers					16
17	Maintenance Workers	3,104	3,256	32,519	9.99	17
18	Housekeepers	26,307	27,432	170,185	6.20	18
19	Laundry	9,468	9,645	52,844	5.48	19
20	Administrator	1,826	2,091	87,873	42.02	20
21	Assistant Administrator	2,828	3,030	59,132	19.52	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,847	6,198	60,188	9.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,100	5,690	97,014	17.05	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	248,232	263,453	$ 3,184,334 *	$ 12.09	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	21	$ 1,105	1-3	35
36	Medical Director	96	4,800	9-3	36
37	Medical Records Consultant	96	4,032	10-3	37
38	Nurse Consultant	monthly	48,516	10-3	38
39	Pharmacist Consultant	60	1,800	10-3	39
40	Physical Therapy Consultant	139	6,928	10A-3	40
41	Occupational Therapy Consultant	95	5,822	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	9	226	10A-3	43
44	Activity Consultant	48	2,193	11-3	44
45	Social Service Consultant	67	3,325	12-3	45
46	Other(specify) Dir. Food Services	monthly	24,996	1-3	46
47	Dietary Consultant - SIR Mgmt	monthly	15,000	1-3	47
48					48
49	TOTAL (lines 35 - 48)	631	$ 118,743		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,995	$ 89,284	10-3	50
51	Licensed Practical Nurses	6,286	127,701	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	9,281	$ 216,985		53

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lori Barrish	Administrator	2.04%	$ 87,873
Cynthia Droste (7/00 - 8/00)	Asst. Admin	0%	4,555
Jacqueline Gully (1/00-7/00)	Asst. Admin	0%	29,392
Margaret Mahoney (6/00 - 12/00)	Asst. Admin	0%	18,031
Erik Malenock (1/00 - 2/00)	Asst. Admin	0%	7,154
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 147,005

B. Administrative - Other

Description	Amount
Management Service Fees (see attached)	$ 85,968
Management Fees (see attached)	434,596
TOTAL (agree to Schedule V, line 17, col. 3)	$ 520,564
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 28,155
Preferred Bookkeeping	Accounting	20,200
Personnel Planners	Unemployment Consultant	2,095
Schwartz & Freeman	Legal	61,174
Katz & Randall	Legal	10,226
Stone, McGuire & Benjamin	Legal	12,622
Stuart Sikes	Collections (adj on p 5)	284
SIR Management	Director of Regulatory Srv	19,848
Preferred Bookkeeping	Bookkeeping Services	82,320
See Attached	Computer Services	7,395
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 244,319

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 38,458
Unemployment Compensation Insurance	26,034
FICA Taxes	243,596
Employee Health Insurance	50,687
Employee Meals	33,687
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	19,089
Union Health & Welfare	59,295
TOTAL (agree to Schedule V, line 22, col.8)	$ 470,846

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	37,138
Health Care Worker Background Check	648
(Indicate # of checks performed 108)	
Licenses & Permits	1,482
Dues & Subscriptions	7,567
Yellow Page Advertising	9,588
Advertising & Promotion	11,020
See Attached Schedule	1,682
Less: Public Relations Expense	( )
Non-allowable advertising	(11,020)
Yellow page advertising	(9,588)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 48,517

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,445
Allocation - Preferred Bkkpg	217
Allocation - SIR Mgmt	674
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,336

**See instructions.

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting & Decorating	1996	$ 34,222	3 years	$ 11,407	$ 11,407	$ 5,704	$	$	$	$	$	$
2	Painting & Decorating	1997	8,074	3 years	1,346	2,692	2,692	1,346					
3	Painting & Decorating	1998	9,860	3 years		1,643	3,287	3,287	1,643				
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 52,156		$ 12,753	$ 15,742	$ 11,683	$ 4,633	$ 1,643	$	$	$	$

Facility Name & ID Number ELMWOOD CARE, INC. # 0040410 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL Council on L-T Care: 6632**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,600** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **134,505**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **33,687** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%-ln 1**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw